

TYPE/PRINT
IN PERMANENT
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ARKANSAS DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
REPORT OF INDUCED TERMINATION OF PREGNANCY
(For Statistical Use Only)

File Date _____
(State Use Only)

1. FACILITY NAME <i>(If not clinic or hospital, give address)</i>		2. CITY, TOWN OR LOCATION OF PREGNANCY TERMINATION		3. COUNTY OF PREGNANCY TERMINATION				
4. AGE LAST BIRTHDAY		5. MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO		6. DATE OF PREGNANCY TERMINATION <i>(Month, Day, Year)</i>				
7a. RESIDENCE-STATE	7b. COUNTY	7c. CITY, TOWN, OR LOCATION		7d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	7e. ZIP CODE			
8. OF HISPANIC ORIGIN? <i>(Specify No or Yes—If Yes, specify Cuba, Mexican, Puerto Rican, etc.)</i> <input type="checkbox"/> NO <input type="checkbox"/> YES Specify _____		9. RACE <input type="checkbox"/> American Indian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other (Specify) _____		10. EDUCATION <i>(Specify only highest grade completed)</i> <table border="1" style="width:100%; border-collapse: collapse;"><tr><td style="width:50%;">Elementary/Secondary (0-12)</td><td style="width:50%;">College (1-4 or 5+)</td></tr></table>		Elementary/Secondary (0-12)	College (1-4 or 5+)	
Elementary/Secondary (0-12)	College (1-4 or 5+)							
11. DATE LAST NORMAL MENSES BEGAN <i>(Month, Day, Year)</i>								
12. CLINICAL ESTIMATE OF GESTATION <i>(Weeks) 12. PROBABLE POST-FERTILIZATION AGE (PPF)</i>								
12 (a). PPF AGE <u> </u> (WEEKS)		12 (b). METHOD OF DETERMINING PPF AGE <input type="checkbox"/> ULTRASOUND <input type="checkbox"/> PHYSICAL EXAMINATION <input type="checkbox"/> LMP <input type="checkbox"/> Other (Specify) _____		12 (c). IF PPF AGE WAS UNDETERMINED, BASIS A MEDICAL EMERGENCY EXISTED				
<input type="checkbox"/> UNDETERMINED <i>(Complete 12c.)</i>				12 (d). IF PPF AGE IS 20 WEEKS OR MORE, BASIS FOR IMMEDIATE ABORTION OF PREGNANCY.				
12 (e). IF PPF AGE IS 20 WEEKS OR MORE, DID METHOD USED PROVIDE THE BEST OPPORTUNITY FOR THE UNBORN CHILD TO SURVIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO <u>IF NO, Specify Basis</u> _____		13. PREVIOUS PREGNANCIES <i>(Complete each section)</i>						
		LIVE BIRTHS		OTHER TERMINATIONS				
		13a. Now Living Number _____ <input type="checkbox"/> None		13b. Now Dead Number _____ <input type="checkbox"/> None				
		13c. Spontaneous Number _____ <input type="checkbox"/> None		13d. Induced <i>(Do not include this termination)</i> Number _____ <input type="checkbox"/> None				
14. TYPE OF TERMINATION PROCEDURE <i>(Check only one)</i> <input type="checkbox"/> Suction Curettage <input type="checkbox"/> Medical (Nonsurgical), Specify Medication(s) _____ <input type="checkbox"/> Dilation and Evacuation (D&E) <input type="checkbox"/> Intra-Uterine Instillation (Saline or Prostaglandin) <input type="checkbox"/> Sharp Curettage (D&C) <input type="checkbox"/> Hysterotomy/Hysterectomy <input type="checkbox"/> Other (Specify) _____				15. CONSENT – answer all three parts <table border="1" style="width:100%; border-collapse: collapse;"><tr><td style="width:33%;">a. Was Parental Consent Required? <input type="checkbox"/> Yes <input type="checkbox"/> No</td><td style="width:33%;">b. Was Parental Consent Obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No</td><td style="width:33%;">c. Was Judicial Bypass Obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr></table>		a. Was Parental Consent Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	b. Was Parental Consent Obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No	c. Was Judicial Bypass Obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No
a. Was Parental Consent Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	b. Was Parental Consent Obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No	c. Was Judicial Bypass Obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No						
16. NAME OF ATTENDING PHYSICIAN <i>(Type/Print)</i>				17. NAME OF PERSON COMPLETING REPORT <i>(Type/Print)</i>				

MAIL TO:

ARKANSAS DEPARTMENT OF HEALTH
CENTER FOR HEALTH STATISTICS

INSTRUCTIONS FOR COMPLETING THE INDUCED TERMINATION OF PREGNANCY REPORT: VR-29

ITEM	INSTRUCTION
1. Facility Name	Enter name of facility or give address if not a clinical or hospital.
2. City, Town, or Location	Enter name of city, town, or location of pregnancy termination.
3. County	Enter name of county where pregnancy termination occurred.
4. Age	Enter age in years of patient at her last birthday.
5. Married	Check "Yes" if the patient was legally married at any time between conception and termination. Otherwise check "No."
6. Date	Enter Month-Day-Year of pregnancy termination (e.g. 10-23-2001).
7. Residence	
a. State	Enter name of state in which patient lives.
b. County	Enter name of county in which patient lives.
c. City	Enter name of city in which patient lives.
d. Inside City	Enter Yes, No, or Unknown.
e. ZIP Code	Enter ZIP code of patient's residence.
8. Hispanic Origin	Check No or Yes; if Yes SPECIFY Mexican, Cuban, Puerto Rican, etc.
9. Race	Check White, Black, American Indian, or Other. If Other, specify.
10. Education	Fill in number for highest grade of school completed. If more than 5 years of college, enter 5+.
11. Date of Last Menses	Enter date that last menses began (e.g. 5-14-2001).

Question No. 12 has been added in accordance with Act 171 of 2013.

12. Weeks Gestation	Enter clinical estimate of weeks gestation. DO NOT USE RANGES (e.g. 6-8).
12. Probable Post-Fertilization (PPF)	
a. PPF age	Enter estimate of probable post-fertilization age. DO NOT USE RANGES.
b. Method	Check method for determining PPF age
c. PPF Age Undetermined	List the basis of the determination that a medical emergency existed.
d. PPF 20 weeks or more	List the basis of the determination that the pregnant woman had a condition which so complicated her medical condition as to necessitate the immediate abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of major bodily function of the pregnant women, not including psychological or emotional condition.
e. Best Opportunity for Survival	Check Yes or No. If No, specify reason for choice of method.

13. Previous Pregnancies	
a. Now Living	Enter the number of live births that are still living.
b. Now Dead	Enter the number of live births that have died.
c. Spontaneous	Enter the number of spontaneous abortions (miscarriages) that have occurred.
d. Induced	Enter the number of PREVIOUS induced abortions that have occurred.
14. Procedure	Check ONLY ONE type of procedure that terminated this pregnancy.

Question No. 15 has been added in accordance with Act 537 of 2005.

15. Parental Consent	Check Yes or No on each item
a. Consent Required	
b. Consent Obtained	
c. Judicial Bypass Obtained	
16. Name of Physician	Enter name of attending physician

17. Staff Person Name Enter name and telephone number of staff person completing this report.